

Virginia Department of Medical Assistance Services Civil Monetary Penalty Funds  
**-COVER SHEET-**

The purpose of the cover sheet is to provide a brief overview of the proposed project, and to ensure eligibility before submitting a full application.

**The cover sheet shall not exceed more than 3 pages.**

**The cover sheet will be accepted between March 1, 2018 until March 30, 2018.**

The full project application can be found here: [http://www.dmas.virginia.gov/Content\\_pgs/ltc-cmp.aspx](http://www.dmas.virginia.gov/Content_pgs/ltc-cmp.aspx)

**Applicant Information**

Date	
Organization Name	
Contact Person Name	
Phone Number	
Email	
Mailing Address	
Medicaid Provider Number (if applicable)	
If applicant is a nursing facility: Do you have any pending CMPs that have been levied against your facility or have you had any penalties levied against your facility in the past two years?	
<input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, please provide details, including the status and amount:	

**Project Information**

Project Title	
Project Category	<input type="checkbox"/> Training <input type="checkbox"/> Direct Improvements to Quality of Life/ Quality of Care <input type="checkbox"/> Resident or Family Councils <input type="checkbox"/> Consumer Information <input type="checkbox"/> Managed Care Value Based Payment Strategies <input type="checkbox"/> Other – please specify:
Brief Description of the Project (1-2 sentences):	

Project Details	
<b>Expected Outcomes:</b> Short description of the intended outcomes, deliverables, and sustainability	

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<p><b>Results Measurement:</b> A brief description of the methods by which the project results will be assessed (including specific measures)</p>	
<p><b>Benefits to Nursing Home/Facility Residents:</b> A brief description of the manner in which the project will benefit nursing home residents</p>	
<p><b>Non-Supplanting:</b> A description of the manner in which the project will not supplant existing responsibilities of the nursing home to meet existing Medicare/Medicaid requirements or other statutory and regulatory requirements</p>	
<p><b>Consumer and other Stakeholder Involvement:</b> A brief description of how the nursing home community (including resident and/or family councils and direct care staff) will be involved in the development and implementation of the project;</p>	
<p><b>Partnering Organizations:</b> List all organizations that will receive funds through this project (to the extent known), and organizations that the State expects to</p>	

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carry out and be responsible for the project	
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**Funding**

Project Timeline	<input type="checkbox"/> <b>1-Year</b>	<input type="checkbox"/> <b>2-Year</b>	<input type="checkbox"/> <b>3-Year</b>
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Total Amount Requested			<b>Total</b>
Amount of Match or In-Kind Contributions (optional)			